

# FOR STATE HEALTH DEPT.

TO DEPUTY JUDICIAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) <b>Capt. HILLRY B.</b>			First Middle Last <b>AKERS</b>			20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year <b>2/12/69 19 11:30 AM</b>			2b. HOUR	
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>6/10/1893</b>		6. AGE (In years last birthday) <b>75</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <b>Feb. 13 1969</b>	2d. HOUR <b>1:30 AM</b>
7a. BIRTHPLACE (State or foreign country) <b>Rock Hall, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Kent</b>				Md.
10. CITY OR TOWN OF DEATH <b>Chestertown (DOA)</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kent &amp; Queen Anne Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Boat captain</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>(Waterman)</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Rock Hall</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Main St.</b>	
14. FATHER'S NAME First Middle Last <b>George Akers</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Martha Sewell</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Merchant Marines</b>			16b. SOCIAL SECURITY NO. <b>217 72 6891</b>		17. INFORMANT ADDRESS <b>Mrs. Kitty Akers - Rock Hall, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Disease</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>several years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Robert W. Farr</b>			EXAMINER'S NAME (Type) <b>Chestertown, Md.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>2/13/69</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2/16/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>near Chestertown, Md.</b>			
24. FUNERAL DIRECTOR <b>J. Wells Wells</b>			ADDRESS <b>Chestertown, Md.</b>			25a. REC'D BY REGISTRAR <b>FEB 17 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

03180

RECEIVED

1951

1951



W. A. R. 1951



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Item 6 Filing 10

3/4/69

02492

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02487

1. DECEASED-NAME (Type or Print) <b>Elwood</b>			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>2 22 69</b>			2b. HOUR <b>2:00 PM</b>		
3. SEX <b>Male</b>			4. RACE <b>Colored</b>			5. DATE OF BIRTH <b>9/17/1929</b>			6. AGE (In years last birthday) <b>39</b>		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Kent</b>		
10. CITY OR TOWN OF DEATH <b>R.F.D. Kennedyville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>At Home</b>			12a. USUAL OCCUPATION (Kind of work done during working life, even if retired.) <b>Labor</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Various</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>			13b. COUNTY <b>Kent</b>			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME <b>Stanley</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Virginia Daughtry</b>			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>2 27-30-729</b>			17. INFORMANT <b>BARKSDALE Terrace</b>			Address <b>3014 Popular</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>890 X</b> <b>Chloroform complete poisoning -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Fire in trailer where he lived -</b> (b) <b>Fire in trailer where he lived -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Fire in trailer where he lived -</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>short</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>2 22 1969</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Trailer caught on fire -</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>			21f. LOCATION Street or R.F.D. No. <b>near Kennedyville</b>			City or Town <b>Kent</b> County <b>Md</b> State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Robert W. Farr</b>			EXAMINER'S NAME (Type) <b>Robert W. Farr M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>2-25-69</b>		
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county) <b>Chestertown, Md.</b>					
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>			23b. DATE <b>3/1/1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Janes Methodist Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Chestertown, Kent Md.</b>		
24. FUNERAL DIRECTOR <b>Jenneth Day</b>			ADDRESS <b>Chestertown, Maryland</b>			25a. REC'D BY REGISTRAR <b>FEB 27 1969</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year				2b. HOUR	
EARL				KENNARD	JONES	Feb	2	1969	4:25 PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		Feb. 6, 1901			67 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Md.		U.S.					Kent Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Chestertown			Kent & Queen Anne's Hosp.			Merchant & Postmaster						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.				Kent		Still Pond		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		—		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Harry Hawkins Jones			Eva Whittington									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No —				218-20-6207		Hospital Records, Chestertown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u> <u>years</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
1-31-69		Cholelithiasis				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Jan 30, 1969, to Feb. 2, 1969, that (I) (we) last saw the deceased alive on Feb. 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE								22c. DATE SIGNED				
A. C. Dick, M.D.								2-2-69				
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS				
A. C. Dick, M.D.								Chestertown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
BURIAL		2-5-69		STILL POND CEMETERY			STILL POND KENT MD.					
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
VICTOR N. KENNEDY STILL POND, MD				FEB 6 1969		Charles Judge						

12488

02493

NAME		LAST		FIRST		MIDDLE	
SALV		JAMES		H		J	
BIRTH		1900		10		10	
DEATH		1980		10		10	
SEX		M					
RACE		W					
RELIGION		C					
EDUCATION		H					
OCCUPATION		F					
MARRIAGE		M					
CHILDREN		3					
PARENTS		F					
SIBLINGS		2					
MILITARY		N					
CIVILIAN		Y					
REMARKS		[Faint handwritten notes]					



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
02494					02489						
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR			
First	Middle	Last		Month			Day	Year			
Medford	Samuel	Jones Sr.		Feb			14	'69	2:25PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		Mar. 14, 1891			77		YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland		U.S.					Kent Co., Chestertown Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown, Md.			Kent & Queen Anne's Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Kent		Chestertown						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First	Middle	Last	First	Middle	Last						
Purnell		Jones	Arbella		Moore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No			220-22-0442		Hospital records Chestertown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u>										10 years	
4124 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Rheumatoid arthritis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan 24, 1969, to Feb 14, 1969, that (I) (we) lost saw the deceased alive on Feb 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								22c. DATE SIGNED			
A. C. Dick, M.D.								2-14-69			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
A. C. Dick, M.D.					Chestertown, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		2/16/1969		Wesley Chapel Cem.			near Rock Hall, Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
J. Wells Wells Chestertown, Md.					FEB 19 1969		[Signature]				





FOR STATE  
HEALTH DEPT.

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02495

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02490

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR					
Jennie						Karbaum		Feb. 11, 1969		5:00 PM					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD					
Female	White	Feb. 25, 1898		70 YRS.		MONTHS DAYS HOURS MIN				Month Day Year					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				2d. HOUR					
Germany		U.S.A.				Kent				9:00 PM					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Lynch								Housewife				Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.				Kent				Lynch				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		---	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Unknown				Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No								Frank Karbaum,				Box 443, Chestertown, Md. 21620			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Robert W. Farr</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type) Robert W. Farr, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				2-12-69							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) <u>Kent</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				Feb. 15, 1969		Sudlersville Cemetery				Sudlersville, Q.A. Md.					
24. FUNERAL DIRECTOR						ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Edward Fellows & Son, Millington, Md. 21651								FEB 14 1969		<u>James Judge</u>					

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02496

## CERTIFICATE OF DEATH

02491

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P M	
Christian			?	Kern	Feb. 21 1969		8:07 M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male	White		5-5-1898		70 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		USA				Kent Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
Chestertown			K & QA Hospital			Farmer		LABOR
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland			Queen Anne		Millington		Ford's Landing	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last					
John ? Kern			Annie ? Welch					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
Yes WW 2			220-30-4921		Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiparesis</u> <u>0360</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>2-20</u> , 19 <u>69</u> , to <u>2-21</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-21</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>A.C. Dick</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>2-21-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>A. C. Dick M.D.</u>					22e. ADDRESS <u>Chestertown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		2/24/69		Oak Lawn Cem.		Baltimore, Co. Maryland		
24. FUNERAL DIRECTOR <u>J. C. White</u> ADDRESS <u>Chestertown, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 25 1969</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Illustration: Herringbone

Pattern

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— 83 12-2 83 00-2 22 20-2

Handwritten notes at the bottom left.

02121

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

McAlpin 02492

1. DECEASED-NAME (Type or Print) <b>William R. McAlpin</b>			2a. DATE KNOWN <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>1969</b>			2b. HOUR OF DEATH ESTI- MATED <input type="checkbox"/> <b>10:00 AM</b>			
3. SEX <b>m</b>	4. RACE <b>w</b>	5. DATE OF BIRTH <b>12-25-1904</b>	6. AGE (In years last birthday) <b>64</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <b>2</b> Day <b>16</b> Year <b>1969</b>			
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>usa</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Kent</b>			
10. CITY OR TOWN OF DEATH <b>Chestertown, Rural</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Farm (at home)</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Banker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Chestertown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <b>Rural</b>			14. FATHER'S NAME First <b>David H.</b> Middle <b>McAlpin</b> Last <b>McAlpin</b>			15. MOTHER'S MAIDEN NAME First <b>Emma</b> Middle <b>Rockerfellow</b> Last <b>Rockerfellow</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO. <b>055 14 1881</b>		17. INFORMANT <b>Mrs. Kathleen M. McAlpin</b>			ADDRESS <b>Chestertown Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bullet wound in head -</b> <b>955X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>self inflicted -</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>none</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>self inflicted</b>		21b. TIME OF INJURY Month, Day, Year <b>2/16 1969</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>self inflicted</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Farm owned by deceased</b>		21f. LOCATION Street or R.F.D. No. <b>Chestertown</b>		City or Town <b>Kent</b>		State <b>MD</b>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Robert W. Farr</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>2-16-69</b>			
EXAMINER'S NAME (Type) <b>ROBERT W. FARR</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <b>Kent</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>2/17/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR <b>J. Willis Wells</b>			ADDRESS <b>Chestertown, Md.</b>			25a. REC'D BY REGISTRAR <b>DATE FEB 19 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last <b>Hester Goldie Moore</b>					2a. DATE OF DEATH Month Day Year <b>2 22 69</b>		2b. HOUR MIN. <b>1.10 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>7-9-01</b>		6. AGE (In years last birthday) YRS. <b>67</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Kent</b> Md.			
10. CITY OR TOWN OF DEATH <b>Chestertown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kent &amp; Queen Anne's</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Chestertown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <b>George Thomas Henry</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Georgiana Rasin</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>144-20-4291</b>		17. INFORMANT Address <b>Kent &amp; Queen Anne's Hospital Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Liver</b> <b>1978</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Six Mos.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>2-10</b> , 19 <b>69</b> , to <b>2-22</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2-22</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>DR Oteiza</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Feb. 25, 69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Jorge Oteiza MD</b>				22e. ADDRESS <b>Chestertown, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/27/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Methodist Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Georgetown Kent Md.</b>			
24. FUNERAL DIRECTOR <b>James H. Smith</b>				ADDRESS <b>Chestertown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02494

# CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Francis Joseph Reskovitz						Feb Month 28 Day 1969 Year			12:55 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male		White		Oct. 14, 1924			44 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Delaware		United States				Kent Co., Chestertown Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown			Kent & Queen Anne's Hosp			Highway Inspector					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Kent		Chestertown						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Ralph Reskovitz			Helen unk								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
Yes			1943-1945		221-12-2706			Hospital Records - Chestertown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure + Coma</u>										2	
5719 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										unknown	
(b) <u>Cirrhosis of liver</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb 4, 1969, to Feb 28, 1969, that (I) (we) last saw the deceased alive on Feb 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R. W. Farr</u>								DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-28-69	
22d. PHYSICIAN'S NAME (Type) R. W. Farr, M.D.								22e. ADDRESS Chestertown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			3/3/69		St. John's Cemetery			Rock Hall, Md.			
24. FUNERAL DIRECTOR <u>J. Wilho Wells</u>						ADDRESS Chestertown, Md.		25a. RECD BY REGISTRAR MAR 3 1969		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

VR 414 45M - 1969



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 1 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A M P		
Henry			NMN	Siejack	Feb 26 1969		12:30		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male	White		April 11, 1909		59 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland	United States			Kent Co., Chestertown Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Chestertown		Kent & Queen Anne's Hosp		Contractor					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER				
Maryland		Kent	Rock Hall						
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Alexander				Siejack	Rose				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
		214 12 8059		Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordial arrest</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>6 days?</u> <u>Years.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Diabetes</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 25</u> , 19 <u>69</u> , to <u>Feb. 26</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Feb. 26</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>A. C. Dick</u>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/26/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
A. C. Dick, M.D.				Chestertown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		3/1/69		St. Paul's Cem.		near Chestertown, Md.			
24. FUNERAL DIRECTOR <u>William Wells</u>				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE MAR 3 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-63)  
30M REV 1/65

02501		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02496									
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M					
Edna						Tolliver	2 Month 7 Day 69 Year								
3. SEX Female		4. RACE Colored		5. DATE OF BIRTH 9/28/1914			6. AGE (In years last birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN				
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent County Md.									
10. CITY OR TOWN OF DEATH Fountain		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) At Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Factory		12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Fountain		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER							
14. FATHER'S NAME Hiram		First Middle Last Wallace		15. MOTHER'S MAIDEN NAME Delia		First Middle Last Simmon									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 420-16-9713		17. INFORMANT William Tolliver		Address 1316 Mon Tello Ave N.E. Washington, D.C.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION (acute) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 6 Months															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 9.19, 1968, to 2.6, 1969, that (I) (we) last saw the deceased alive on 2.6.69, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Geza Koralewski M.D.										DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2.8.69.	
22d. PHYSICIAN'S NAME (Type) Geza Koralewski M.D.										22e. ADDRESS Millington, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/11/69		23c. NAME OF CEMETERY OR CREMATORY Fountain Cemetery		23d. LOCATION (City or Town) (County) (State) Fountain Kent Maryland									
24. FUNERAL DIRECTOR Kenneth Waller		ADDRESS Chestertown, Md.				25a. REC'D BY REGISTRAR DATE FEB 13 1969		25b. REGISTRAR'S SIGNATURE							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Nora Mae Walraven						Feb., 21, 1969 Month Day Year		9:00 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		10-5-1889		79 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Q. A. Co.		USA				Kent		Chestertown	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	
K. & QA Hospital		Nursing Home Worker				Maryland		Queen Anne Sudlersville	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Daniel Edward ? Cannon		Jennie V. Buckle		no		222-12-0455		Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardio-Respiratory Collapse									2 hr
DUE TO, OR AS A CONSEQUENCE OF (b) <del>Heart</del> A. S. C. V. Disease									2 days
DUE TO, OR AS A CONSEQUENCE OF (c) Post-operative Atelectasis & Pneumonia									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2-19-69		Cholelithiasis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.					
22a. I certify that (I) (this hospital) attended the deceased from 2-14-69, to 2-21-69, that (I) (we) last saw the deceased alive on 2-21-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
[Signature]		2-21-69		Arthur T. Keefe M.D.		Chestertown, Md.		[Signature]	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb. 24, 1969		Sudlersville Cemetery		Sudlersville, Q.A. Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE			
Edward Fellows & Son, Millington, Md. 21651		FEB 26 1969		[Signature]					

